

## DRUG MEDI-CAL RESUBMISSION FORM:

County \_\_\_\_\_ Provider Number \_\_\_\_\_ Claim Mo/Yr \_\_\_\_\_

Program Code \_\_\_\_\_ Service Function Code \_\_\_\_\_ Units of Service \_\_\_\_\_

Total Amount Claimed \_\_\_\_\_ Total Records \_\_\_\_\_

Only claims that have been processed and denied can be resubmitted. Providers have up to 6 months from the denial date to resubmit claims that were denied. The following documents are necessary when resubmitting a claim. Please check below to indicate your enclosures:

\_\_\_\_ Hard copy original (ADP 1584) or disk/tape with printout. Please label as resubmission and separate claims by batch number. (For example, if resubmitting two claims which are identified in the denied claims report under batch numbers #341999061001 and #341999062001, please use separate ADP 1584 forms or separate disks/tapes for each number.)

AND

\_\_\_\_ Copy of denied report must be included

OR

\_\_\_\_ Error Correction Report deleting initial claim. This option is to be used only when it is not possible to correct a problem through the normal error correction process. Please check with your assigned Fiscal Management Branch Analyst.

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